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BRIEFING NOTE

Date:	**March 17, 2017**	
Agenda item	**NH Medical Staff Rules Review: Explanation for Changes**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Northern Health Physicians**	

The following represents a high level summary of the proposed major changes to the current NH Medical Staff Rules. Formatting changes, grammatical and typographic errors, and general edits to language found in the current NH Rules are not referenced in this summary.

Similarly, those revisions to the current Rules which resulted from re-writing and consolidating articles or sub-articles for improved clarity, but did not substantially change the existing NH Rules' content, are also not specifically highlighted.

The NH Medical Staff Rules major proposed changes, and the reasons for them, are as follows:

Article 1 – Definitions

New definitions include: BC Medical Quality Initiative, core privileges, deputy chief of staff, Doctors of BC, facilities engagement agreement, inpatient, medical assessee, medical trainees, Ministry of Health, most responsible provider, non-core privileges, Northern Health, outpatient, and provincial privileging dictionaries.

Article 2 – Membership and Appointment

In Article 2.2, the word "procedural" has been removed because privileges apply equally to both procedural and non-procedural privileges (such as documenting a patient's medical history, completing the admission orders, etc.). The word "procedural" has also been removed in multiple other places throughout this document so that only the word "privileges" is used consistently.

In Articles 2.2.2 and 2.2.4, core and non-core privileges replace the previous terminology of basic, major, and advanced privileges. This change continues throughout the latest draft document. Thus, the revised NH Rules will reflect the language consistently used to describe privileges in the provincial privileging dictionaries, developed under the direction of the BC

Medical Quality Initiative, to standardize the terminology used for privileging of medical staff across all BC health authorities.

In Article 2.6 (Review of Appointment and Privileges), the change in language allows discretion for department heads and NH facility chiefs or deputy chiefs of staff to review each member's appointment to the medical staff, and privileges granted, every two years rather than annually. This will provide some flexibility and allow NH appointed leaders to focus on those members who require yearly review. The consultative process may suggest a minimum of 3 years or some other time frame.

In Article 2.7 (Performance Evaluation), the suggestion is to require each member to undergo an in-depth performance evaluation at least every 3 years, rather than annually, at the discretion of the department head or chief/deputy chief of staff. Currently this does not occur annually for a variety of reasons, including that it is an onerous (but important) process and would require significant additional human and financial resources to review each and every member's performance annually. However, Article 2.7.2 details some situations which require certain members of the medical staff to undergo a performance evaluation at specific times.

In Article 3 (Medical Staff Appointments for Medical Trainees and Medical Assessees) the various categories of medical trainees are reorganized to include their scope of activities, registration/licensure requirements as defined by the CPSBC, and their need to hold appropriate professional liability insurance coverage satisfactory to NH Board.

Article 3.5 (Medical Assessees) is a new category of temporary staff which allows for certain physicians to undertake a time-limited competency assessment to determine whether or not they are safe to enter the independent practice of medicine with a provisional class of registration under sponsorship of a health authority and the supervision of a physician approved by the CPSBC. For example, this category of medical staff membership could be used for those PRA-BC candidates undergoing a 12 week clinical field assessment.

Article 4.9.6 (Deputy Chief of Staff) is new and defines the position of a deputy chief of staff who holds a similar role and specific responsibilities as those of the chief of staff. This was a consistent recommendation of key NH medical leadership because in many smaller NH facilities, where no formal department structure is in place, the chief of staff assumes those duties normally conducted by department Heads. This is proving to be a very onerous task and the addition of deputy chiefs of staff will improve the timeliness and quality of oversight of medical staff in smaller facilities.

Article 5 (Medical Staff Complaints, Discipline and Appeals Processes) has not been reviewed/revised or amended. It was extensively revised and approved by NH Board in May 2016.

Article 6 (Responsibilities for Patient Care) contain several significant changes. Specifically, **Article 6.1** is new and defines a Most Responsible Provider (MRP) as the member (e.g. physician or midwife) who has the overall responsibility for the management and coordination of each patient's care at any given time. Specifically, the MRP is the member who admits the patient and completes the admission orders. He/she remains the MRP until another member

agrees to become the new MRP. Transfer of MRP requires direct communication between the members and documented acceptance of this transfer of MRP designation in the patient's health record for all care providers. This article also lists important responsibilities/principles which apply to the MRP. This new article has been requested by NH medical leadership to address ongoing problems in identifying and being certain who is the patient's MRP.

Article 6.3 (Medical Consultations) contains new content and language, stipulating that requests for specialist consultation must be initiated by direct provider to provider communication. The specialist consultant or his/her designate must attend the patient within the expected and defined response time established by NH policy. Before or following completion of the consultation, both members must mutually agree to the designation of the appropriate MRP, in the best interests of the patient.

Article 6.3.3 is new and describes 3 types of consultation requested: consultation only, consultation and directive care, and consultation and transfer of patient care to the specialist consultant, who becomes the new MRP in this circumstance. This addition provides clarity as to the type of consultation requested by a member and to which member maintains or assumes the role of MRP.

Article 6.9.2.3 (Maximum frequency of required on-call by a member) has been changed to define "reasonable on-call frequency" as requiring members to be on-call no more frequently than one–in-three (3) unless the member specifically agrees otherwise. This reflects the reality of what happens in medical practice in most rural and remote NH communities where discipline specific members are often no more than 3 in number. The current NH Rules stipulate that a member shall be required to be on-call no more frequently than one-in-five (5). NH medical leaders support this change.

Article 7 (The NH Medical Staff Association (Representation)) has been extensively revised and shortened. The reality is that medical staff associations in NH are not universal at this time. Reference is made to the current NH Medical Staff Bylaws which already detail medical staff association organization and describe the duties, obligations, and responsibilities along with the rights of NH medical staff. For the present time, it is acknowledged that medical staff associations may be organized in accordance with the Facilities Engagement Agreement between NH, the BC Ministry of Health, and the Doctors of BC. Future amendments to the NH Medical Staff Rules will likely incorporate new definitions of medical staff association organization/structure and the purpose, role, responsibilities, and functions of NH medical staff associations as they evolve over time.

Article 8 (Northern Health MAC and Standing and Other Committees of the Medical Staff) has been reorganized so that the organizational, purpose, composition, and duties of the NH MAC and the subsidiary MACs, which report to the NH MAC, are delineated in Article 8 of the NH Medical Staff Bylaws and in the terms of reference approved by the NH Board. This article clarifies and describes other committees of the medical staff, including specific NH MAC standing committees whose terms of reference are specified in the NH MAC terms of reference. The title of this article has been changed to more clearly describe the context.

Article 9 (Amendments) contains changes to the Rules amendments processes so that it does not specify a medical staff association that does not exist.